MID-STATE HEALTH CENTER
Where your care comes together.

Mid-State Health Center:
Authorization to Release/ Disclose Protected Health Information

Patient Name: _____ **DOB:** _____

Instructions: Complete all applicable sections to have information disclosed **FROM** or **TO** Mid-State Health Center (MSHC). Refusal to complete this form will not affect the quality of or access to care, condition of treatment, payment, enrollment or eligibility for benefits.

Patient Notice – This Section Applies to All Requests

Note: This is a required section and must be completed in its entirety.

_____ I hereby authorize to disclose/ release my protected health information (PHI) orally or in writing **FROM**:

☐ Mid-State Health Center
101 Boulder Point Dr Suite 1
Plymouth, NH 03264
(P)603-536-4000 (F)603-536-4001

☐ _____
Organization Name:
_____
Address:
_____ _____
Phone # Fax #

(Check all that apply) ☐ Medical ☐ Behavioral Health ☐ Dental ☐ IOP/Substance Use Disorder ☐ **All**

A. I request that the information be released for the following purpose: (**Initial** all that apply)

_____ Transfer of Care _____ Attorney/ Legal _____ Billing or Claims _____ Review Request
_____ Continuing Care _____ School _____ Insurance _____ Other: _____
_____ Personal Use _____ Military _____ Financial Aid
_____ Disability _____ Self-Pay

B. I request that the information be released **TO**:

☐ Mid-State Health Center, 101 Boulder Point Dr Suite 1, Plymouth NH 03264 (P) 603-536-4000 (F) 603-536-4001
☐ Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

☐ Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

C. All **record requests** will be delivered in an electronic format (CD or via electronic file portal), unless otherwise specified. Please initial requested delivery method:

_____ Electronic File (CD) _____ Other: _____ _____ In Office Pick-Up (valid photo ID required)*

*To retrieve this information in person, a valid photo ID will be required for patient privacy and confidentiality purposes.

*I understand that a processing **fee may apply** for the requested information.

_____ I understand that my medical record may be incomplete and that additional documentation may be added when received

Records requested are in an electronic format (e.g. CD) unless paper specified above. Electronic signatures are not accepted.

☐ **MEDICAL Records – Initial ONLY Items That Apply**

A. Information to be released:

_____ **Complete Medical Record** _____ Implant Records _____ X-Ray(s) _____ Billing Records
_____ Office Visit Notes _____ Laboratory _____ Ultrasound/Sonogram _____ Demographics
_____ Consultation Reports _____ Medication Lists _____Images ONLY _____ Family Studies
_____ History & Physical _____ Pathology Report _____ Reports ONLY
_____ Immunizations _____ Psychiatry _____ Explanted Materials, Devices, Hardware
_____ Other: _____

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____

C. Specific Treating Provider Name(s): _____ OR _____ All Medical Providers

D. Specific Clinic/ Service(s): _____ OR _____ All Medical Services

☐ **DENTAL Records- Initial ONLY Items That Apply**

A. Information to be released:
_____ All Dental Records _____ Dental Images (XRays) _____ Dental Office Notes

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____

C. Specific Treating Provider Name(s): _____ OR _____ All Providers

☐ **BEHAVIORAL HEALTH Records – Initial Only Items that Apply**

A. Information to be released:
_____ All Behavioral Health Records _____ Specific Provider: _____

B. Date(s) of information to be released (MM/YY): From _____ To: _____

_____ **I understand that psychotherapy notes will not be included unless authorized under 45 CFR 164.508(a)(2).**

IOP/SUBSTANCE USE DISORDER – Initial Only Items That Apply

**** Must complete Authorization to Disclose Substance Use 42 Part 2 Form ****

Patient Acknowledgement – This Section Applies to All Requests

This authorization form does not authorize the release of Substance Use Therapy Records. A separate Authorization to Disclose Substance Use 42 Part 2 Form must be completed.

- I understand that the information in my health record may include information relating or referencing: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- I understand that I may revoke this authorization in writing at any time, except to the extent that MSHC has relied on this authorization. The written revocation should be addressed to the Health Information Management Department. Unless otherwise revoked, I understand that the date upon which this authorization **expires is 180 days** unless otherwise specified _____.
- I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

_____	_____	_____
Patient's Printed Name:	Patient's Signature:	Date:
_____	_____	_____
*Legal Representative's Printed Name:	Legal Representative's Signature	Date:

***Note: Proof of legal authority may be required for legal representatives**

Return Form to: **Mid-State Health Center**
Health Information Management – Release of Information
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
Phone: 603.536.4000 **Fax**: 603.536.4001
Email: medicalrecords@midstatehealth.org